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GYNECOLOGY.

Some Unusual Cases in Abdominal and Pelvic Surgery.

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Read before the Western Association of Obstetricians and Gynecologists, Omaha, Neb., December 27, 1894.

Mr. President and Fellows—Only a few years ago surgery of the abdomen and pelvis was confined to such a limited number of operators, and therefore not sanctioned by the vast majority of physicians and surgeons, it was especially essential that current medical literature should be filled with the reports of cases.

In abdominal and pelvic work most of the cases are without special interest to the general practitioner, and so common to the specialist, that it is hardly worth while to occupy the time of this society by referring to them.

The few cases which I shall report have occurred in my practice since we convened at Des Moines, Ia., last December.

Perhaps I may be pardoned in making the statement that, aside from the cases I herewith report, I have had a large number of very difficult and trying cases, including a goodly number of hysterectomies, with a mortality of 3 per cent.

Case I.—Pyometra, tumor weighing thirty ponds; operation by cœliotomy; recovery:

Mrs. F., aged 22, married for three years, mother of two children, the younger three months old at time of operation. The history of the case as given by her attending physician, Dr. Billingsley, of Belleville, Kas., is about as follows: Nothing unusual occurred in parturition, and recovery was rapid until about the twelfth day, when Mrs. F. had a hard chill accompanied by tenderness in the lower abdomen. From this on she complained constantly of chilly sensations and great soreness above the pubis, soon involving the entire abdomen in tenderness. About one month after the birth of the child, she noticed an enlargement in the region above the uterus, which caused her some alarm, and her physician was summoned. Nothing definite was determined regarding the cause of her condition, and temporary treatment was prescribed with a view of watching the case. Mrs. F. rapidly grew large, and at the same time weak and thin in flesh. Her temperature chart during this time was not taken, but the history shows there must have been some fever. The abdomen growing so rapidly caused her physician to be alarmed regarding her condition, and he corresponded with me, giving me the history about as I have stated. This was about ten weeks after the birth of the child. I was not able to diagnose the condition without seeing the patient, and informed the physician that it would be best to have her come at once to my hospital. The arrangements were made as soon as possible, and she came about twelve weeks after her confinement. Her appearance was most pitiable; a tiny little woman, weighing not over eighty pounds, with a tumor as large as though she was at full time gestation. Her pulse ranged from 140 to 160 per minute, and temperature from 101° to 104° F. Upon examination, I was impressed that the tumor must be of pus, because all the symptoms pointed to that condition. Digital examination revealed the fact that the uterus was involved in the tumor, but so obscure were the conditions, I resorted to the use of the sound to confirm my diagnosis. Instead of confirming my diagnosis, I was led to be-

lieve that I had been in error, that the uterus was not involved, because of the fact that the sound passed into the uterus two inches and a half, indicating almost the normal length. Two other physicians examined the patient, and they also were uncertain regarding the diagnosis. The patient was placed on concentrated food, such as beef juice, milk, eggs, etc., and frequently bathed with water and alcohol, with a view of increasing her strength and vitality for the ordeal of an operation. Instead of improving, the patient rapidly failed under the careful regime, and we were obliged to operate to save her life. The operation was done upon the diagnosis of a pus tumor in the abdomen, without knowing its exact origin. Incision was made in the median line of the abdomen, and in order to reach the pus sac we found it necessary to go through a muscular wall below the peritoneum, which enabled us to diagnose our tumor as of the uterus without any further delay. The pus was let out rapidly, and removed from the room as fast as possible, on account of its very offensive odor. I attempted to separate the uterus from the abdominal parietes, but found it impossible to do so; the uterus and the abdominal wall were one solid growth. I then enlarged the incision up to and beyond the umbilicus, only to find that the intestines and uterus in that part of the abdomen were one mass of adhesions. I separated a few coils of intestine, but finally had to abandon that part of the work, because the patient was apparently dying on the table.

Nothing now remained to be done but to inform the husband that his wife could not recover were we to do more operating, and there was no chance for her to recover if we did not complete the operation. While dissecting as above described, the opening into the pus sac had been kept closed by large tissue forceps. The intestinal peritoneum was so much injured in the dissecting process that the Paquelin cautery had to be used extensively to control the oozing. After thorough irrigation by the use of hot water, I closed the upper portion of the abdominal incision by interrupted deep sutures of silkworm gut; I next sutured the uterus to the abdominal wall tightly to prevent the possibility of pus entering the peritoneal cavity; this thoroughly done, I washed and scraped the pus cavity, removing large quantities of shreds of pus; then inserted a glass drainage tube and put the patient to bed to die, as I supposed. In four hours after the operation her temperature had fallen from 104° to 100° F., the pulse had gone down to 120 from 160, when the patient was first placed in bed. The after treatment consisted of the most nutritious diet, and frequent irrigation of the pus cavity through the glass drainage tube. After forty-eight hours the patient seemed to be entirely out of danger, and from this on recovery was rapid and uneventful. One week after the primary operation, Mrs. F. was again placed on the operating table for the purpose of making an opening through the uterus by way of the cervical canal to the pus sac. This was done by means of a blunt sound passed up and crowding the uterus into the abdominal incision, so that I could cut down onto the sound from above. I then passed a rubber drainage tube through this opening, enabling me to drain the pus per vaginum. The drainage tubes from this on were rubber, glass, and bone, as the case progressed. The patient went to her home four weeks after the operation, with the abdominal incision healed save a small sinus for drainage, and with a bone drainage tube in the cervical portion of the uterus. Mrs. F. has made a perfect recovery, and has been doing her own work for several months. There is still a sinus in the abdomen the size of a goose quill, and probably always will be; but it does not cause her any trouble. The most important feature in the history of this case is the fact that the uterus was involved and formed the tumor wall, and at the same time enough of the uterus was normal at the time of the examination to indicate that the uterus was not involved. So far as I could judge, only that portion of the uterus above the Fallopian tubes or the extreme fundus was implicated in the tumor formation.

So far as I have any knowledge of the matter, this is quite an unusual case. The

pus removed weighed thirty pounds. In order to complete the operation ante mortem, it was necessary to administer frequent heart stimulants hypodermically.

Case II.— Dermoid cyst weighing thirty pounds; recovery.

Mrs. M., aged 32, married, mother of two childred, 10 and 12 respectively. Always in good health until within the last year, since which time she has lost strength and flesh quite rapidly, and when brought to my hospital by her physician, Dr. Janes, of Williamsburg, Kas., was quite weak, although able to walk about the house. The tumor had been growing for a number of years, but its growth was so gradual that the patient had not considered her condition critical until quite recently. The tumor was diagnosed ovarian cystoma of the left ovary. Upon opening the sac with the trocar, we were confronted by complications entirely unlooked for. The cyst contents was so thick that it would not flow through the trocar at all freely, and soon we discovered that the trocar was blocked by sebaceous matter, causing us to abandon its use entirely. The fluid portion of the cyst was removed as best we could, and the incision enlarged so as to enable the large tumor to be removed through it. An ovarian hæmatoma the size of a large orange was removed from the right side.

We washed the intestines quite like one would wash linen, as some of the contents of the cyst had escaped into the abdominal cavity. The abdomen was closed without drainage, and the patient placed in bed without the least shock. Her complete recovery was rapid and uneventful. She returned to her home in four weeks after the operation. The unusual feature in this case is the nature of the contents of the sac, a portion of which I herewith present you for examination. There was a large quantity of long straight hair, several bunches of which grew from the cyst wall, and a large quantity of loose hair in short pieces, floating through the tumor contents, and a portion of which formed nuclei for what I call the "moth balls," of which there was about one gallon and a half. These balls, or marbles, as you will see by the specimens which I present, vary from the size of moth balls as manufactured and sold by druggists to the size of small walnuts. They seemed to be composed of sebaceous matter, and were evidently formed around the short hairs by the motion of the fluid in walking and riding. There was some tissue resembling true skin attached to the inner wall of the sac, a portion of which is also found in this jar. My friend and assistant, Dr. J. L. Gilbert, professor of histology and pathology in the Kansas Medical College, has kindly prepared these drawings, which nicely represent the histological peculiarities of this sebaceous matter.

So far as I know, only one case of the kind has been reported, and that by Dr. Munde. I have occupied your time to report this case, because it seems of unusual interest to me, on account of the peculiar formation of the sac contents.

Case III.— Large ovarian cyst, universal adhesions, hemorrhage controlled by several yards of sterilized gauze; recovery.

Mrs. D., aged 60, widow, mother of seven children, the youngest 13 years of age; gives a history of mental hallucinations amounting to confirmed insanity, and has been confined in the asylum most of the time for the past six years. The asylum records give no history of tumor growth upon her entrance into the institution. No examination had been made until about six months ago. At this time her health began to fail, and the tumor rapidly grew, revealing a condition which caused the asylum attendants some alarm. I saw the patient in consultation with the superintendent of the Topeka asylum, and recommended an early operation in order to save the patient's life, without any thought, however, that her mind would be improved by operative procedure. Owing to the many delays so common in institutions of this kind, the operation was postponed until the patient was reduced to such a critical condition that I considered it unsafe to attempt the operation at the asylum, where skilled nurses could not be had, and brought her to my private hospital. The contents of the sac was readily carried off by the trocar. Every inch of the

cyst wall was firmly adherent to the abdominal peritoneum and to the intestines, so that the dissection was tedious, and the bleeding alarming. To control the general oozing, several yards of iodoform gauze was tightly packed into the abdominal cavity, and allowed to remain for twenty-four hours. The patient was placed in bed more dead than alive. Salt water per rectum, hypodermic injections of strychnia, digitalin, etc., resorted to, and the patient rapidly recovered. Her mental condition was apparently natural after the first twenty-four hours. She went to a boarding house in Topeka, five weeks after the operation, a perfectly well woman, both physically and mentally, and has remained so for three months.

I do not report this case with the view of putting on record the fact that this patient has temporarily recovered her mental equilibrium as the result of this operation, but, nevertheless, it is interesting to be able to make this statement. That she may have a return of her mental aberrations is to be expected. In addition to what has already been said, I may note that the uterus was firmly bound in the retroflexed position, which may account largely for her insanity. I cannot state that this condition was present when she was admitted to the asylum. There is, however, necessity for more thorough investigation by competent specialists of all cases, giving a history of pelvic disease when admitted to asylums.

Case IV.—Insanity with homicidal tendencies, diseased pelvic organs; complete recovery.

Mrs. S., aged 27, mother of two children, aged 2 and 4 years: History of fair health until about one year ago, when she was attacked by violent hallucinations, and attempted on several occasions to take her own life, to escape the terrible catastrophe which she supposed was about to overtake her. Her confinement in the asylum had been of short duration at the time I was called to see her in consultation with the superintendent..

Upon examination, I found the uterine adnexa enlarged and firmly adherent and extremely tender. I recommended the total extirpation of the appendages as the humane thing to do, and also expressed the hope that the patient's mental equilibrium would be restored by the operation. The husband was sent for and readily consented to the plan, and the operation was done at the State Insane Asylum, in Topeka, July last. She was discharged from the institution four weeks after the operation, and has remained entirely well ever since. The time is too short to state that the patient's mind has permanently recovered, but I am of the opinion that she will never have a recurrence of her mental trouble at any time.

Her case is of more than usual interest to neurologists.

Case V.—General peritonitis; patient bed-ridden for one year; two operations; recovery.

In reporting this case I must vary from the program blocked out at the beginning of this paper relative to the work of this present year, by saying that the first operation was performed in October, 1893.

Mrs. G., aged 29, married twelve years, mother of one child born ten years prior to her sickness. Always healthy until January, 1893, at which time she had a severe attack of la grippe, which left her in a very critical condition and confined to her bed, where she remained without getting up for about eight months. I saw the patient the first week in October, 1893, in consultation with Dr. Harvey, of Council Grove, Kas. Her suffering was largely confined to her pelvic organs. She had been treated by her physician for inflammation of the pelvic organs and general peritonitis, but without relief. Her temperature had ranged from 100° to 104° F., and pulse 120 to 140, for months at a time. The night before I saw her, after hours of extreme suffering, there was a discharge of fluid per vaginum, of what she supposed to be at least one gallon in quantity, leading her to believe that she was pregnant, and that the amniotic fluid had escaped. Prior to this discharge of fluid the abdomen had been considerably distended, making her condition very obscure, and causing her physician to treat her expectantly. Mrs. G.'s suffering was so intense that the neighbors often heard her screaming a long distance from the house. At the

time of my visit she was quite free from pain, partly the result of morphia taken in large quantities the night before. There was general tympanitis, and the pelvic organs were so sensitive that it seemed cruel to complete the examination. The uterus and appendages were firmly fixed and surrounded by plastic exudation. There was almost constant vesical tenesmus, and micturition caused extreme suffering. I unhesitatingly recommended prompt operative interference, with the view of removing the the diseased adnexa, separating adhesions, etc. Mrs. G. was eager to have something done at once, but her weakened condition made the risk very great, and her husband was opposed to any attempt being made to remove her to a hospital for an operation. However, her physician insisted that an operation presented the only hope for recovery, and after some preparation she was placed on a cot bed, taken to the depot in a spring wagon, then placed in a baggage car and brought to Topeka, where she arrived October 16. It has never been my misfortune to have seen such a corpse-like woman traveling on the cars seeking health; none but the bravest would attempt such a herculean contract. After a few days of preparation I performed a cœliotomy, with the following result: Every portion of the omentum lying next to the bladder was adherent to that organ, making it necessary to ligate and sever it; the appendages were buried out of reach and could not even be outlined; there were many bands of adhesions, which narrowed the lumen of the intestine. These adhesions were severed, and the bowel released so far as was possible under the circumstances; a Paquelin cautery was used quite freely to control oozing where ligation was not possible, and the incision was closed without drainage. The patient improved rapidly without any untoward symptoms. When she returned to her home, seven weeks after the operation, she was able to walk to the carriage. Mrs. G. gained in flesh and strength, and was soon able to do light housework, go to parties, and enjoy herself generally.

In March, 1894, Mrs. G. one evening indulged in a hearty meal of boiled cabbage, etc., and a few hours afterwards was attacked with a hard chill, accompanied by severe pain in her bowels, followed by persistent vomiting, which continued unabated for several days. There was at no time complete obstruction of the bowel. Most of the symptoms pointed to appendicitis. During this time her temperature was often as high as 105° F.; and pulse 140. Her physician had but little hope of her recovery. After remaining in bed about eight weeks, she was again brought to my hospital, in order that she might receive careful nursing and judicious diet. My diagnosis of her condition was that she was suffering from peritonitis, due to an attack of appendicitis, and I recommended another operation as the only means of relief. During the four weeks of her stay in my hospital prior to the operation, which occurred July 12, on almost every occasion when there was a bowel movement the suffering was so great that we had to keep her alive by artificial stimulation and the use of morphia in large doses. One of the peculiar conditions, the like of which I have never seen before, was that the epigastric region would sink in toward the spine during these attacks, making an inundation that would permit a small cocoanut to be buried out of sight. Her temperature at these times would often be 104° F., and pulse 160. Mr. G. would not consent to another operation until he had fully concluded that his wife was about to die. Dr. Harvey was summoned, and upon his urgent request permission was given for a second operation, Dr. Harvey, with several other physicians, being present. It was found necessary to remove the entire large omentum, after breaking up the universal adhesions that were found. The cæcum was firmly adherent; so also were several inches of the ascending colon. The uterus was found in normal position, firmly fixed as it was at the time of the first operation, with the appendages hidden by plastic exudation, and no attempt was made to disturb these organs, as it was found impossible to even make an opening through the exudate. There were no adhesions of the small intes-

tine. Thorough irrigation was used and the abdomen closed without drainage. The patient sustained but slight shock. Twenty-four hours after the operation Mrs. G. was convalescing, and her recovery from this on was uneventful. She returned to her home in five weeks, and has never suffered a pain from that day to this, so far as I know. A letter recently received from her states that she is entirely well, fleshy, and rosy-cheeked, and the happiest woman in Ohio, where she is now visiting. The appendix vermiformis was not found, but there is no doubt in my mind that there was perforation of this organ at the time of the attack in March.

The unusual features in this case are too numerous to again refer to, as the history proves. The conditions were grave from the start to the finish, and the operations were performed under the most trying circumstances, upon an apparently dying patient, the second operation, requiring the removal of a large amount of tissue, and the separation of extensive intestinal adhesions, making the operation so grave that it was enough to turn one's hair white.

Case VI.—Retroflexion and fixation of the uterus; intestinal complications; long invalidism; recovery.

Miss F., aged 27, by occupation teacher, came to me with the following history: Her menstruation has always been painful, and during the past few years often confined her in bed for one or two days. In June of this year Miss F. Consulted a lady physician, who at once diagnosed her trouble to be stenosis of the cervical canal, and resorted to daily dilation as a means of relief. This treatment was given at the doctor's office, and only required a few repetitions to set up an extensive peritonitis, which caused the patient to take her bed. Miss F. was not long in discovering that the treatment she was receiving would soon end her existence, and wisely—or perhaps I might say unwisely, as the sequel will prove—changed physicians. She was immediately informed that the treatment she had received was not at all indicated and extremely dangerous in its character. (To this I give my hearty approval.) The treatment recommended and carried out by this distinguished gentleman(?) was to daily attempt to replace a retroflexed and fixed uterus by means of a sound, at the same time the patient was suffering from peritonitis, as above stated. This treatment caused such unbearable suffering that on two occasions the patient was anæsthetised and treated as follows: The first operation consisted of complete dilitation of the cervix, and attempt to replace the uterus by the sound; curettment of the endometrium, and packing the uterine cavity with gauze. He also dilated the urethra and stretched the rectum for the purpose of curing some hemorrhoids. This treatment made the patient very ill, and her friends thought her recovery impossible. Ten days after this operation the doctor made his first examination and found the uterus was again retroflexed and more firmly adherent than ever. She was again placed under anæsthesia, and a second attempt made to replace the uterus by the use of the sound. How successful was this treatment I cannot say. The patient, after some weeks of severe illness, resulting from the treatment received by both physicians, and only kept alive by the skill of a trained nurse, who worked over her night and day, was taken to her home from a hospital still too ill to leave her bed. In spite of this condition, the doctor thought that he must treat that uterus by some process or other, and, in order to have a change in the program, his brilliant mind suggested electricity. Thus the poor girl was tortured, first by one process and then another, until Dame Nature revolted, and the doctor, exhausting his last remedy, permitted her to have the much needed rest by discontinuing his treatment. It only required a very short period of time for nature to come to the rescue, and enable the little lady to resume her avocation as a teacher. Under much suffering, often greatly prostrated by weakness, she continued her work for a few weeks before applying to me for my opinion. I found upon examination a firmly adherent retroflexed uterus, and a pelvis full of exudate. The abdomen would often be as much enlarged as a woman at seven months pregnancy. My diagnosis was chronic salpingitis, peritonitis and in-

testinal adhesions. I urged prompt operative interference as the only rational means of relief. As soon as matters could be arranged, Miss F. came to my hospital for an operation. A very short incision was first made to enable me to pass two fingers into the pelvis for diagnostic purposes. The omentum was universally adherent to the abdominal and intestinal peritoneum. After severing the adhesions so as to enable me to reach the pelvis, I was somewhat shocked to discover that no uterus or appendages could be found. Lying on the rectum a small mass could be felt, which, of course, was the uterus, but so thoroughly veiled that its outline could not be deciphered; the same was true of the appendages; nothing could be made out as even resembling tubes and ovaries. I next addressed my attention to the cæcum, as the history pointed to a lesion of this bowel. It was so thoroughly adherent that it required much time and patience to deliver it so that it could be examined; the injury done to the bowel was quite severe, making it necessary to suture a portion of it, and to control hemorrhage by the use of the Paquelin cautery. The consulting physician, not a specialist in diseases of women, but an eminent member of the profession, suggested that it was not possible to complete the operation. However, in view of the fact that the patient had not been shocked, my judgment dictated that I would be cowardly not to attempt to remove the cause of her suffering. After long-continued and almost superhuman effort, I made an opening through the the thick, tenacious membrane which veiled the uterus and appendages, and as rapidly as possible removed the right appendage, which was firmly adherent to the cæcum, making it necessary to ligate the distal end. The proximal end of the tube was literally torn from the uterus, so that ligation was impossible. The hemorrhage was profuse and really alarming. (I desire to state in this connection, that I enlarged the incision up to the umbilicus soon after beginning the operation, thus affording ample room for the trying ordeal of the occasion.) As rapidly as possible I severed the adhesions of the left appendage from the bowel and pelvic fascia. Although I succeeded in transfixing and ligating the broad ligament, as is customary, the ovary and tubes were removed in pieces. Both tubes were many times the normal size, indicating long and serious salpingitis. Pus was found in both tubes. Having succeeded in bringing the uterus forward to its normal position and freed of its appendages, I felt certain that my patient would recover without a bad symptom, provided I could control the hemorrhage. After the use of a very large quantity of hot water irrigation, I packed the pelvis tightly with sterilized iodoform gauze, closed the upper and lower angles of the incision, introduced some provisional sutures, applied a tight bandage over thick compresses, and placed the patient in bed apparently without shock. Time of the operation one hour and twenty minutes. The gauze was left in situ for forty-eight hours, when it was removed and a smaller quantity introduced. I then tied the sutures which had been introduced, nearly closing the incision, leaving only enough of opening to permit drainage. Miss F. seemed to convalesce from the hour she was placed in bed, as her pulse and temperature were never above normal. There was a bowel movement within twenty-four hours without the use of laxatives. The patient's recovery is complete; we never had a more satisfactory result, even in the most uncomplicated cases.

I am impressed, when considering the gravity of this case, that one's life could not be better spent, if one were to give up all else, and disseminate to every land and clime the fact that the world would be better and happier if every physician in it who is in the habit of resorting to the dirty sound or uterine dilator in the treatment of cases similar to the foregoing, was stricken by Divine Providence from the face of the earth. Recently, in reviewing her sufferings under the treatment received, Miss F. suggested that, in the days of the inquisition, when women were hung up by the thumbs and toes, and tortured in various and sundry ways, had they been acquainted with this mode of torture it would have taken the place of all others in its severity.

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Conservatism.

IT has been previously announced in the columns of this journal that an effort would be made to divide the subject matter published in such manner as to insure the most ready comprehension of the various medical topics.

When a medical journal is made up of several articles on as many different subjects, the reader is at once reminded of what has been termed many times as "shotgun practice," signifying that the old fusee is loaded with all sorts and kinds of ammunition, and when it is discharged it is bound to hit something or somebody.

There is a special advantage to be derived from more painstaking compilation, by publishing in each number several articles relative to one branch of medicine and surgery, namely, the convenience of making files for future reference.

The KANSAS MEDICAL JOURNAL does not pretend to take the place of journals published weekly in large cities, but its scope and field of usefulness have become widely recognized, and we trust that if we are able to carry out the plan suggested above, i. e., publish one week, articles on surgery; another, gynecology, obstetrics, general practice, pathology, therapeutics, etc., we shall confidently expect a large increase in circulation, and trust that the JOURNAL will occupy a conspicuous place on the table of every member of the profession in this State.

Publishers of medical journals should endeavor to furnish their readers with medical news by diffusing a spirit of fairness, which includes the old as well as the new, and the new as well as the old.

It has always been, and still continues to be, true that a few must lead and the great mass follow in every science. The greatest danger to be feared in carrying out such a law is the utter lack of personal investigation. Medicines are prescribed, treatment outlined, surgical operations recommended, all because some one else has led the way, and the balance follow with their eyes half closed.

The readers of the JOURNAL will notice that this number is largely composed of matter from the pens of prominent members of the profession who are thoroughly wedded to operative interference in many of the grave cases of pelvic diseases, which were formerly, and are by many at the present time, treated almost exclusively on the expectant plan. It is to be hoped that in reading this number no one will lose sight of the fact that any or all of the gentlemen who have furnished these articles are as ready and willing to treat patients on what has always been termed the conservative plan, as are others who have said less about surgical operations. The only difference lies in the fact that some surgeons and physicians have had an experience so satisfactory, from operations performed on patients

who have been subjected to treatment from month to month and year to year without benefit, to be afterward entirely cured by simple surgery, as compared with others who have had no experience in surgery for the relief of these conditions, that one is liable to misinterpret the teachings of those who are called radicals, when the fact is, they are more conservative oftentimes than the procrastinators.

We all have to contend with a small degree of prejudice, which is universally inseparable from the human mind, and more often than we are willing to admit influences our judgment, and prevents investigation and research so essential to progressive science. The greatest good to the greatest number will be done by those who strive to know the truth from every standpoint, and who have the bravery to carry out their convictions regardless of public opinion or mercenary motives. It oftentimes requires much sacrifice of money and friends to always give patients conscientious advice. The members of the profession who are doing the best work and having the best results, are not by any means the ones who are making the most money.

Gynecological patients may be treated for months and years on the conservative plan, provided their physician assures them, as he always has to do, that each treatment will give them much relief. There may be a few instances where physicians have such unlimited influence over their patients that no questions are asked, and the patient comes for her treatment twice a week for months, and perhaps years, fully believing that all will be well in due time. Others are expected to give an opinion as to the time required to effect a cure, and the patient readily assents to the opinion given. These practitioners are the ones who may wear diamonds, and live in palaces, and spend three months of the year abroad, because they will always have a *clientele* which insures them a large and permanent income.

There is a happy medium, which we should endeavor to discover, between too much and too little surgery. This line of demarcation can only be discovered by a thorough personal investigation, and laying aside every vestige of prejudice that is so likely to lurk in our minds.

The Management of Pregnancy.

Dr. D. L. Burnett, of Vermont, has published a paper on this important subject in the *American Gynecological and Obstetrical Journal*, in which he says:

"In my experience, one of the most trying complications of the pregnant state is the occurrence of uncontrollable vomiting. We have all types of this trouble from the slightest feeling of nausea in the early morning to the hyperemesis that takes the life of both mother and fœtus. The animal, mineral and vegetable kingdoms have all been searched for a remedy or even a palliative. Mechanical means and local applications have all been vaunted, and still we are without a trustworthy expedient for relief. Laceration or erosion of the cervix, faulty position of the uterus, indulgence in sexual intercourse, gastric or intestinal catarrh, constipation, and in the later months distention and many reflex causes, these all — nay, many others — come in as the causes, and our treatment must be as varied as is the ætiology; and alas! even then are we many times doomed to disappointment.

"One of the first things to do is to relieve any constipation, using a seidlitz powder either alone or with bromide of soda. Fluid extract of cascara sagrada does excellent service also. Sexual intercourse should be prohibited in all cases that do not yield readily to treatment. Rest in bed is important. One of our best authorities — Lusk — recommends of all medicinal agents ten grains of bismuth subnitrate with five or ten grains of oxalate of cerium, taken ten minutes before eating. Half a drachm of chloral hydrate combined with forty or fifty grains of bromide of potash or soda in milk as a rectal injection very often is satisfactory. Some recommend the chloral in a suppository or capsule. I have never used it in this manner, but should imagine it would have too much of an irritant effect on

the rectal mucous membrane for the patient's comfort. Nux vomica in gastric catarrh does good service. Fowler's solution, chloral hydrate, the bromides, atropine, drop doses of iodine, carbolic acid, ingluvin, dydrocyanic acid, pepsin preparations, alcohol in its various forms, or the inhalation of oxygen in its various forms, may succeed in individual cases. Ice-cold effervescing drinks are of use. Cocaine, either by the mouth or incorporated with vaseline as an ointment to the cervix, has some friends. Instances are on record of hypnotic suggestion apparently causing a cure. Try to nourish the patient. Hot or cold milk given with lime-water frequently and in small quantities will sometimes be retained. Beef tea, beef peptonoids, whites of eggs beaten with brandy, gruels, etc., give a variety of means of nourishment. If the food cannot be retained at all it is well to use hypodermics of morphine either alone or combined with atropine, and followed in thirty minutes by the nourishment. The influence of the opiate will quiet the reflex activity of the stomach and allow digestive and assimilative processes to take place. Complete rest of the stomach by partial or complex rectal feeding is a method to be utilized. Malpositions of the uterus should be corrected. Copeman's method is well and favorably known. Any lacerations or erosions of the cervix should be treated *secundum artem*. After all the methods of treatment enumerated the vomiting may still continue. The woman is emaciated, pulse frequent and weak, tongue parched and brown, urine scanty and perhaps albuminous, sordes on lips and teeth, disorders of the special senses, delirious, horrible eructations of gas from the stomach, vomiting incessantly, or perhaps there is a cessation of the emesis, which is to be looked upon with suspicion, as it is many times the forerunner of death. Ere we reach this fatal stage, and while the woman is yet able to bear the ordeal, an abortion should be produced. This should not be done till after mature deliberation, and with the advice of other practitioners. Nature sometimes steps in and takes the responsibility off our shoulders; but an expectant line of treatment must not be continued too long, as many, many fair lives have been lost by this same expectancy.

"Care should be taken not to use evacuants that act by an irritant effect on the intestinal mucous membrane, or that produce a congested condition of the pelvic organs, for fear of a possible interruption of the gestation. If the urine is scanty and albuminous, the salines and diaphoretics are indicated.

"If the œdema involves the legs and vulva, and something seems necessary to be done, tonics should be administered, one of the best of which is the misturi ferri et ammonii acetatis, or Basham's mixture, which from its tonic and diaphoretic properties is especially indicated. Hot applications are useful. Saline purges, by increasing the hydræmic condition of the blood, increases the trouble. If the swelling and tension is so intense that gangrene of the skin is feared, puncture may be made with antiseptic precautions.

"If there are distinct inter or re-missions, quinine may be used with a good hope of success. Morphine should be a last resort. Many times the pain only ceases with the end of gestation. Insomnia is usually one of the minor discomforts, but its long continuance places the woman in a condition of lowered vitality for undergoing the pains of labor. We should see that she is in a proper hygienic state and takes plenty of fresh-air exercise, also that she avoids any excitement or worry. The use of stimulating hot sponge baths, followed by a brisk rubbing at bedtime, is a useful and simple expedient. Some of the milder sleep-producers, as valerian, camphor, cannabis, indica, etc., may be used. Sulphonal is an excellent remedy."

The most important suggestion made by the author is the resort to rectal alimentation exclusively, and rest in bed until the vomiting is controlled. After this the patient must be closely watched, because the first indiscretion will cause a return of the vomiting.

The Mechanism of Lacerations of the Pelvic Floor.

Dr. E. F. Tucker, of Oregon, has given the profession some valuable hints upon this subject in the *American Gynecological and Obstetrical Journal* for December:

"In most of our text books, if we look up the ætiology of this injury, I think the impression would be gained that these injuries are caused by an overdistention of the vagina or vulvar orifice by the child's head, while, as a matter of fact, the real damage is caused by an overstretching or a loss of continuity of some of the fibers of the levator ani muscle.

"The fact of the matter is, that it seems impossible to rid the general practitioner—to whom so many of these cases come for relief—of the idea of a 'perineal body,' and of the necessity, in its absence, to construct an artificial one by building up a barrier of scar tissue at the vulvar orifice. Some of our even more recent text books seem to have a tendency to maintain this idea by devoting space to anatomical descriptions of the perineal body.

"The symptoms and anatomical results of lacerations of the pelvic floor have been well and thoroughly described, more particularly in America by Emmet, Skene, and Kelly. The anatomy of the levator ani muscle and its physiological functions have been thoroughly studied by Dickenson and others; but the special part played by this muscle in delivery of the head does not seem to me to have been sufficiently dwelt on.

"In an ordinary normal occiput anterior position the head descends flexed, pushed on by a force from above, acting more or less in the direction of the axis of the superior state; rotation gradually takes place, and the occiput comes under the pubic arch; the head meets with the resistance of the pelvic floor, extension follows, and the head is born. The interest of the gynecologist begins at that point where the head commences to press on the pelvic floor. The direction of the force which is pushing the child downward remains about the same throughout labor; so that, although the occiput may be under the pubic arch and protruding through the vulva, the contractions of the uterus and abdominal muscles tend to drive the anterior portion of the head toward a point somewhere between the tip of the coccyx and the anus. These parts yield to this pressure, the coccyx being forced backward, the anus backward and downward, to such an extent that it gapes wide open. The posterior commissure of the vulva is forced almost directly downward a distance corresponding to the cervico-bregmatic diameter of the head, whereby the distance from the tip of the coccyx to the vulvar opening is about doubled; and the child would now be pushed right into the world through the rectum—as has happened—were it not for the levator ani muscles, which by their contraction tend to drag the head forward and out under the pubic arch so long as their continuity is intact. I believe that at this period in delivery the head rests, as it were, in a sling formed by the pubo-coccygeal portion of the muscle, and that the perinæum itself is never put on the stretch so long as these muscles hold; a rigid perinæum is a rigid levator ani; furthermore, that the lower fibers of this muscle aid in the act of the delivery of the head, favoring extension by drawing up the occiput and expulsion by drawing forward the head, the ischial portion at the same time tending to retract and slip back the perinæum over the advancing head.

"If it were not for the resistance offered by this muscle, the vaginal wall and the skin perinæum would not hold out long against the pressure exerted from above by the uterine contractions and the voluntary efforts of the abdominal muscles brought into play at this stage; if the levator ani acted merely as a sling to support the head and nothing more, it seems to me it would merely be a question which muscular force was the greater, whether the uterus would succeed in tearing the levator ani, or whether the levator ani would completely arrest labor, either of which accident sometimes happens. But grant this muscle the

power of shunting the head forward, as it were, and the child is born with perhaps no further injury to the mother than a slight nick of the vulvar orifice, which possesses no clinical significance.

"As I have already stated above, unless this muscle tears or gives way, the pelvic floor or perineal tissues cannot be injured; but if any of its fibers become sufficiently torn or separated to allow the head to press on the vaginal wall, rectum, or perinæum unsupported, they must necessarily give way under the force from above, and the tissues are torn, as a rule, proportionately to the tear of the levator ani muscles. I say as a rule, because sometimes in complete lacerations through the recto-vaginal septum we find no obliteration of the fold between the buttocks, and the anus and vagina drawn pretty well forward toward the pubic arch—conditions generally absent when the levator ani is extensively damaged. In these cases, I believe, the fibers which are inserted around the vagina are torn through or away from their attachments, but those which pass behind the rectum are merely torn loose from the rectum, and slip backward and upward from under the head, thereby saving themselves but sacrificing the recto-vaginal septum. Again, we find cases of 'relaxed perinæum' where there has been no external wound apparent, and yet evidences of injury to the pelvic floor are manifest. In these cases there has occurred a submucous tear of some of the fibers of the levator ani, or else the muscle has become more or less paralyzed from overstretching, and has failed to regain its normal tone.

"Injuries to the pelvic floor occur more frequently in malpositions of the head, simply because some longer diameter of the head comes under the pubic arch, thereby increasing the strain on the levator ani muscles—that is, forcing their point of attachment further down and away from their point of origin.

"Most of the directions given to save the perinæum by introducing one or more fingers into the rectum and pushing the head forward are merely efforts to assist the levator ani to do its work. Support of the perinæum by pressure directed upward can be of no avail if the head cannot be pushed forward, as the levator ani must stretch downward sufficiently to allow the head to pass under the pubic arch. Violent voluntary contractions of the abdominal walls at this period, I believe, often cause lacerations, while chloroform and artificial assistance would prevent them.

"As to the best method of repairing these injuries, I can only quote from Dr. E. C. Dudley, who, I think, struck the keynote to the whole question when he told his students: 'You will have learned the greatest lesson in perinhaoreaphy when you apply the elementary principle, that in the repair of a wound the essential purpose is to restore the wounded part to its original state.'

"The pelvic floor has a function, and it is that function which needs to be restored."

Inflammatory Disease of the Uterus and Appendages and of Pelvic Peritoneum.

At the meeting of the American Association of Obstetricians and Gynecologists held in Toronto, Canada, Dr. W. W. Potter, of Buffalo, N. Y., said, regarding inflammatory diseases of the uterus and appendages, and of the peritoneum:

"What I shall have to say will be of a general character, leaving the several special branches of the subject to be presented by the referees whose names appear under the respective headings.

"To-day we know that it is impossible to separate the inflammation of serous and cellular tissues in the pelvis either clinically or histologically; that pelvic cellulitis is a very rare condition; and that pelvic inflammation is in almost every instance peritonitis caused by disease of the ovaries or tubes, or both. We know, too, that a frequently recurrent pelvic peritonitis is strongly suggestive of leaky tubes.

"The newer pathology under which we are working to-day further teaches us that

pus originating outside of the tubes or ovaries in the non-puerperal state is a very rare condition; that is to say, pelvic abscesses are, speaking generally, pus tubes.

"By far the largest number of women in our consulting rooms to-day are those suffering from pelvic inflammation in some form, in either its primary or secondary stages, and who justly demand relief from an acute attack or expect a cure from the residues that are mercilessly ravishing their pelves. Tumors, cystic or solid, malignant growths, tubercular disease and the like, that constitute grave an undisputed reasons for surgical relief, though observed with a surpassing frequency, are in small minority as compared with the myriads who suffer from inflammatory diseases of tubes, ovaries and pelvic peritoneum.

"Within the past seven or eight years, however, a greater uniformity of opinion on this subject has prevailed among physicians who may be classified as well informed. They are agreed that in all pus cases—and these constitute the majority—excision and drainage should be the rule; that leaky tubes causing recurrent pelvic peritonitis should be removed; that tentative measures are of little avail and are only to be employed where radical methods cannot be invoked; and especially that electricity not only does not cure but is capable of doing positive harm.

"Under this increasingly satisfactory state of uniformity of opinion many women have been cured who otherwise would have been lost to the community either in death or chronic invalidism.

"Hardly have we become settled down to a policy that is yielding the largest measure of favorable results when there comes a mandate from unexpected sources, like a thunderbolt out of a clear sky, crying: 'Halt! Cease your radical, even though they be curative measures, and adopt conservatism in the management of these conditions.'

"The application of the word conservative in this relation is so misleading that much harm comes from its use. Every gynecologist and abdominal surgeon believes in true conservatism. We all believe that every organ in the body should be preserved when it can be done without a menace to health or life. We believe in resorting to the knife only after it becomes apparent that through the knife lies the surest, safest and quickest avenue to restored health.

When, therefore, men talk about tinkering with diseased organs that are rendered useless for procreation or utterly destroyed in function and structure, menacing health and life in their progressively destructive disease, it cannot be called properly conservatism. To asseverate that such cases can be restored to health through the employment of rest, massage, electricity, a general building up of the whole system, and by topical treatment, is to presume upon the credulity of the poor patients, but it scarcely will convince an enlightened and wary profession.

In the majority of women suffering from these inflammations or their sequelæ there is inability to meet the financial demands of a residence of six months or a year in a fashionable private hospital. This kind of conservatism is an expensive toy that the wealthy may play with, because their very wealth accords them privileges that perforce must be denied the poor.

"The result of all this is not difficult to comprehend. Deserving women who need surgical operations for their cure are frightened away from the operating rooms of skilful surgeons, hence are prevented from obtaining relief, and thus go on from bad to worse until the end.

"Now, must we go all over the argument again in view of these so-called conservative doctrines that are being preached on every occasion and published to the four winds? Must the ground all be fought over again in order to let these suffering women understand, as they had already come very largely so to do, that their only safety lies in submitting themselves to the careful hands of skilful pelvic surgeons who are the true conservators of their health and lives? I hope not.

"I trust that this association will on this occasion so put the stamp of its disapproval

on the clever but dangerous teaching of these clever though dangerous men as to counteract its ill effects and to stem the tide of erroneous, misguided, and hazardous doctrines that are springing up therefrom in the columns of the medical press."

Dr. Potter is a gynecologist of large experience and extensive observation, and he cannot fail to impress the most conservative that there is truth in every statement made. Suffering women need more men of the stamp of Dr. Potter, and fewer "big-men-afraid-of-their-shadows."

Treatment.

Under the head of "Treatment of Diseased Appendages," etc., Dr. A. Van Der Veer, of Albany, N. Y., suggests:

"A young girl is brought to us, or a young woman, who has been an invalid for five years. She is compelled to give up school. In such a case we must carefully inquire into the condition, learn as to what may be the actual cause of the inflammatory condition that exists about the pelvis. The question will occur to you: Has she had for three or four years a persistent leucorrhœa? Has she become infected in some manner with a purulent discharge, not necessarily specific, but by some form of abscess or sinus that has existed? I have found in one case a well marked inflammatory condition of the pelvis due to an uncured ischio-rectal abscess that one time discharged into the vagnia. This condition should be looked into with the utmost care and caution. Irritations about the rectum should be carefully looked for in young girls who present a condition of this kind.

As to the condition of the appendages in a young girl in early life, we should ask ourselves the question: Has nature accomplished her work well? Has she developed the uterine appendages in a proper manner? Has the girl, from the time the menstrual act was noticed, had a normal menstruation? In many cases we will find that menstruation has been irregular; that the patient has always suffered; that she has had perhaps an abscess, an ischio-rectal abscess or an ovarian abscess, which has escaped through one of the lymph channels, through which nature will often make an exit for the pus. She may have an undeveloped ovary tube on one side. These causes should be looked into carefully before carrying out an intelligent line of treatment.

"As to the cases occurring in the adult, the married or unmarried woman, these must also be examined with the utmost care. If the patient has borne children the condition of the cervix should be examined with great care. That noble man — Dr. Emmet — has done great work for us in reference to the lacerated cervix. The condition we seek may rest within the cavity of the uterus, while the tubes are absolutely free from disease. There may be no trouble outside of the cavity of the uterus. But you begin with your tincture of iodine, with your various applications; you begin curettment, and perhaps then you light up an inflammatory condition, and the patient is finally made worse by the line of treatment carried out. Make a careful examination, and, if the cause be a lacerated cervix, it must be repaired.

"I must say I do not feel like condemning the curette entirely, for I believe it is of service in some cases. When we have a high temperature with a rapid pulse we should not go inside the uterus with a sharp curette. Do a gentle form of curetting, then pack the uterine cavity with iodoform gauze, and the patients will be benefited. In two or three days you may have a case of pyosalpinx that needs a more radical operation. You need not ignore the use of the curette entirely. It may be used in cases of endometritis. In the submucous form of polyp you can perhaps use the sharp curette. No one can cover the conditions present in these cases by one simple examination. The cases should be carefully studied and then the line of treatment selected.

When a case comes to us with an inflammatory condition of the pelvis, I do think we are justified always in saying to the pa-

tient that the uterine appendages must be removed. The condition must be outside, when operation is not necessary. On the other hand, how many of you have seen those cases that have passed from office to office and from city to city, where there has been absolutely no relationship for years and years on the part of the husband and wife, perhaps, the husband having spent his hard earnings from week to week in going to this and that doctor, they telling him they could cure his wife without operation; and finally the case goes into the hospital with all the complications, with all the sorrowful conditions present of immense pus tubes opening into the rectum— the saddest of all conditions. *Then we are to operate. It is unfortunate that we do not get these cases earlier.*

There are cases where the cornu of the uterus is in a thickened condition, bimanual examination will not cause the woman to complain, and the uterus is somewhat fixed. In these cases I believe we can do some good by local thorough douchings, putting the woman under a sensible, cautious line of treatment. The old suppository of lead and belladonna, to be held there and renewed, the patient being kept absolutely quiet, will materially benefit these patients. Furthermore we must look into the condition of the bowels; see that they are thoroughly emptied every day. We have patients that come to our office for examination and we find that the bowels have not moved in two or three days, and they expect a careful examination of the pelvis to be made. The condition of the bowels, therefore, must be studied carefully, as well as the bladder. We may be able to carry some of these cases through successfully by this line of treatment without removal of the appendages, but the vast majority of cases of pelvic inflammation will ultimately necessitate such an operation."

Dr. Joseph Price adds to the testimony of Dr. Van Der Veer:

"The surgery that leaves pus tubes and abscesses to get well of themselves, and afterwards find pregnancy occurring, is so fabulous and mystical that I prefer simply to wonder without caring to understand or believe. What we have here referred to incidentally leads to a broader reference to pelvic pathology. To understand the limitations of conservatism, especially as applied to subsequent conception, it is necessary to consider the complexity of the pathological processes which militate against every chance of the organs regaining their physiological function. Pus tubes are not simple. It is the rule to find them with multiple constructions, and with the tube simply a wire line, its lumen a wreck.

"Many of the operations now successfu were formerly failures because of the insufficient knowledge of how to deal with the wounded gut, how to make an anastomosis or do a bowel resection. Hence it is to be put down as a postulate in pelvic surgery that no man has a right to attempt it who does not know how to deal with all the complexities of intestinal surgery. To know *when* and *when not* to stitch intestine is as necessary as to know *when* and *when not* to operate.

"What are we to say as to the removal of the entire uterus in the presence of tubal and ovarian disease? I take it that if all the pathologists who have ever examined uterine structure which is purely muscular —or, to be more exact, in great part muscular—were to make a report, there would be a general concensus of opinion that an abscess condition of the uterine walls, apart from broken-down fibroid, is the rarest condition imaginable, except at the cornu in case of pyosalpinx.

"In conclusion, we are to remember that enough has been done of all kinds of pelvic work to decide what is the general drift of results, how far they are satisfactory and how far disappointing. The end here should justify the means, not in the hands of the disappointed experimentalist, but in the careful, painstaking surgeon."

Dr. J. F. W. Ross, of Toronto, gives his personal experience with pus tubes. When

to operate; how to operate; and the results of the operation, as follows:

"I believe there is a time when a man should not operate on such cases, but he has no right to prevent others from doing what they know and he knows is best for the patient—namely the enucleation of such pus sacs.

"In looking back over my records I find that the fatal cases were chiefly those in whom gonorrhœa had been contracted but a short time before. I now believe that it is not wise to operate on these cases too soon after the primary infection. It is better to wait until the pus has become to a certain extent sterile and until the poisonous germ has become attenuated.

"The history of these cases previous to operation would fill an enormous volume. There would be in the volume many tales of woe. There would not be much in the volume that would be flattering to the so-called 'treatment' received by these patients before surgical measures were resorted to. One woman has begun to live her life over again. She was for fourteen years bedridden; she grew old as the town grew up about her. The operation was very difficult, but, contrary to the expectations of all, she never had a bad symptom after its completion. She is at present enjoying life and in perfect health. Many of the other cases had been through other hands and had been under the care of various physicians, until at last they reached the care of the more enlightened young men of the rising generation and were transferred to me for surgical interference.

"We must conclude, then, that there is a danger in operating on these cases at too early a period after the primary infection, and there is certainly a want of wisdom in deferring operation beyond a certain point. No case should be operated on during the first acute attack, except under very exceptional circumstances.

"I am firmly convinced that none but those who have had the advantage of a special training in this department of surgery should undertake the operations for the relief of cases such as those under discussion.

"There is a certain method of procedure that should be followed in each of these cases. In the first place, it is necessary to draw up the anchored omentum and to do so rapidly. The portion from which an anchored omentum has been peeled will not bleed, but the proximal portion of the omentum itself will bleed freely, and this bleeding should be carefully attended to. If, after it has been placed temporarily to one side, wrapped in a sponge, while the rest of the operation is being carried out, it is found that it still bleeds, no time should be lost, but fine ligatures should be applied around the bleeding portion and the rest should be cut away beyond the ligatures. The omentum should never be tied with coarse silk; the very finest silk should be used for this purpose.

"*Results of Operation.*—In some cases the menstrual flow ceases. There is usually a slight flow, coming on. In some cases this may return no more. I have one patient who has been menstruating regnlarly ever since her operation nearly four years ago. I was at a loss to know why this was until I looked up my record and found that both tubes were removed, but that one ovary could not be found, owing to the fact that the tube on that side had burst into the broad ligament and produced an abscess of the broad ligament that was drained. This proved conclusively to my mind that the removal of the tubes did not have much influence on the function of menstruation. The patients pass through the usual symptoms of the menopause. Those who have become emaciated by the long-continued suppuration rapidly put on flesh. When dyspareunia has existed before operation, it disappears after convalescence, and the patient is much less unsexed in this respect than she was before. The patient who before operation has been living in her bedroom is now enabled to live in the outer air and is transferred from the invalid carriage to her own feet; the doctor is not now so frequently a visitor to the house as in former years, and happiness is restored to the home.